

Registration Form:

Patient's Full Name: _____

Date of Birth: _____

Today's Date: _____

Preferred Name: _____

Address: _____

City, State, Zip Code: _____

Cell Phone Number: _____

Email: _____

Spouse/Parent Name: _____

Purpose of Call: _____

Patient's Social Security #: _____

How did you hear about our office? _____

Other family members in our practice: _____

Emergency Contact's Name and Phone #: _____

Dental Insurance Coverage:

Subscribers Name: _____

Subscribers Date of Birth: _____

Employer: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Telephone of Insurance Company: _____

Policy #: _____

Local Group #: _____

Subscribers Social Security # and ID #: _____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that my possible dental benefits are a contract between my provider and I and in no way a contract with Allen Dental and that Allen Dental is independent of Insurance companies. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor after 30 days of nonpayment by my dental benefits provider.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____

Date: _____